CAMPER MEDICAL HISTORY FORM

(To Be Completed by Camper's Parent/Guardian and returned to the Edgewater Recreation Department.

No camper will be permitted to attend camp without this form. Please Print.)

Name _____ Date of Birth _____ Height _____

Address _____ Gender M F Weight _____

City, State, Zip _____

Father's Name _____ Mother's Name _____

Father's Home Phone _____ Mother's Home Phone _____

Father's Work Phone _____ Mother's Work Phone _____

Father's Cell Phone _____ Mother's Cell Phone _____

Family Status: Married Divorced Separated Single Widowed Other

Parent to contact 1st in Medical Emergency: _____

Emergency Medical Information (Circle)

Asthma	Convulsions	Fainting Spells	High Blood Pressure
Contact Lenses	Diabetes	Heart Trouble	Migraine Headaches

Allergy or reaction to any medicine, food, plants, and/or animal/insect toxin. Yes No (If yes, please explain)

_____

_____

Any other condition that may require emergency or special care, medicine or knowledge? Yes No (If yes, please explain)_____

_____

Does your child require an Epi-Pen? Yes No

Has your child ever needed an Epi-Pen administered? Yes No

Does your child need to sit at a Nut-Free Lunch Table? Yes No

---

Insurance Information

Insurance Carrier/Plan Name: _____

Insurance Carrier Address: _____

Insurance Policy Number: _____

Group Number: _____

Medical Contact Information

Camper's Physician:_____

Phone: _____

Camper's Dentist: _____

Phone: _____

PLEASE ATTACH UP TO DATE (CURRENT) IMMUNIZATION RECORDS

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Medical History

Any Past or Present History of: (*please circle*)

Back, Limbs, Joints	Yes	No	Heart	Yes	No	Serious Illness	Yes	No
Behavioral Condition	Yes	No	Heart Murmur	Yes	No	Serious Injury	Yes	No
Braces/Retainer	Yes	No	Hernia	Yes	No	Sinus	Yes	No
Chest, Lungs	Yes	No	Immune Deficiency	Yes	No	Skin, Glands	Yes	No
Contact Lenses	Yes	No	Kidneys	Yes	No	Stomach/Bowels	Yes	No
Deformity	Yes	No	Menstrual Problems	Yes	No	Surgery	Yes	No
Ears	Yes	No	Nose/Nosebleeds	Yes	No	Teeth	Yes	No
Eyes	Yes	No	Physical Limitations	Yes	No	Tonsils	Yes	No
Head Injury/Concussion	Yes	No	Pneumonia (recurrent)	Yes	No	Urine Infection	Yes	No
Hearing Aid	Yes	No	Rheumatic Fever	Yes	No	Other (explain below)	Yes	No

Please explain any Yes answers

_____

_____

_____

Is camper currently under medical care? Y N (If Yes, Explain)

_____

_____

Does camper take any medication? Y N (If Yes, Explain)

_____

_____

Does your child require a shadow at school? Y N Why?_____

Has camper been diagnosed with ADD or ADHD? Y N

Does camper take medication for ADD or ADHD during the winter? Y N

Will camper take the same medication for ADD or ADHD during the summer? Y N (If No, Explain)

_____

AUTHORIZATION

To the best of my knowledge, the medical history is correct and complete. I know of no reason to restrict camper activity and give my permission for participation in all activities. I give permission for Edgewater Recreation staff member to administer an emergency Epi-Pen if deemed necessary. In the event I cannot be reached in an emergency, I hereby give permission to Edgewater Recreation Camp to take my child to the hospital or any outside physician selected by the camp when deemed necessary. Furthermore, I hereby give permission to such hospital or physician to hospitalize, secure proper treatment for, and/or order x-rays, routine tests, medications, injections, anesthesia and/or surgery for my child named above, without limitations. I understand that all medical bills for services rendered by anyone other than the camp's medical staff are my responsibility. I authorize the release of any medical information or records related to treatment, referral, billing or insurance purposes related to my child.

I further authorize the camp medical staff to discuss any medical conditions with the Director, his/her designee, or my child's counselor(s) when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child.

Parent or Guardian Signature _____ Date _____

EDGEWATER RECREATION MEDICATION AUTHORIZATION FORM

Participant's Name: _____ **Date of Birth:**_____

We highly recommend and encourage that medications be administered prior to or after the camp session, however, we recognize that there may be occasions where medicine may need to be administered with supervision during the camp day. Any medication other than rescue medications (Benadryl with epi-pen, epi-pen, or asthma inhaler) will only be administered with supervision at a location where a camp nurse is present such as Edgewater Recreation Camp.

1. All prescription and non-prescription medication (over the counter) require a physician's authorization and shall be labeled and stored in the original prescription container.
2. All medication is maintained under staff supervision and the staff supervises the administration of this medication. The only exception to this is Asthma inhalers, which may be carried on the person, but must be clearly labeled with doctor's protocol.
3. Parents/Guardians must sign the medication authorization for below.

Parental Request

I, the parent/guardian of _____ request that the rescue/prescription medication prescribed by my child's physician be administered to my child by a trained staff member (for rescue medications only such as epi-pens, Benadryl with epi-pens or asthma inhalers) or the camp nurse (for other prescribed medications for campers at Edgewater Recreation Camp). The medication will be brought to camp in its original container appropriately labeled by my pharmacy.

_____ _____

Signature of parent/guardian Date

_____ _____

Address Home Phone Number

_____ _____

City State Zip Cellular Number

Physician's Authorization

In order to protect the health of _____, it is necessary for him/her to have the following medication during camp hours.

MEDICATION:

_____

DOSAGE: _____

TIME to be administered: _____

Purpose of medication: _____

List of any possible side effects: _____

I authorize the camp nurse or qualified staff member to administer the above medication.

Signature of Physician _____ Date _____

Print Physician's Name _____ Phone _____

Address _____

CAMPER INFORMATION FORM

Communication

Can your child:	Speak English	Y	N
	Understand English	Y	N

Safety

Does your child:

Stay with a group	Y	N
Recognize danger	Y	N
Follow simple directions	Y	N
Wander/Run away	Y	N
Know their phone number	Y	N

Personality/Behavior

Describe the best way to get your child to participate into an activity:

_____

Is there any additional assistance we can provide your child to help them participate successfully in a camp setting?

_____

Describe any setting or activity that may cause behavior difficulties:

_____

What is the best way to redirect or engage participant's attention?

_____

Describe the type of situations that frustrates your child?

_____

Does the participant use a specific plan for behavior? Y/N. If so, please describe.

_____

Does the participant act out? Y/N. If so, please describe.

_____

Describe the type of behavior management or reinforcement that works best:

_____

Please list any phobias.

_____

EMERGENCY TREATMENT AUTHORIZATION FORM

To Whom It May Concern:

As a parent and/or guardian of_____a minor, I hereby authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent/GuardianName:_____

Address:_____

City/Town:_____State:_____ZipCode_____

Daytime Phone Number ( )_____-_____

Evening Phone Number ( )_____-_____

Cell Phone Number ( )_____-_____

MEDICAL INFORMATION:

PhysiciansName:_____

HospitalChoice:_____

Physician's Phone Number ( )_____-_____

Indicate specific medical allergies, chronic illnesses, or other medical conditions coaches, instructors, and medical personnel should be aware of:

Other person to contact in case of emergency:_____

Person's relationship to child:_____

Persons Telephone Number ( )_____-_____

Persons Evening Number ( )_____-_____

THIS RELEASE FORM IS COMPLETED AND SIGNED OF MY OWN FREE WILL FOR THE SOLE PURPOSE OF AUTHORIZING MEDICAL TREATMENT UNDER EMERGENCY CIRCUMSTANCES IN ABSENCE.THIS WAIVER WILL COVER MY CHILD FOR ALL RECREATION ACTIVITIES FROM JUNE 1 – SEPTEMBER 1, 2019.

SIGNATURE_____DATE_____